

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/26/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 290027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER GROVER C DILS MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 N SPRING ST, BOX 1010-C-ADM BLDG CALIENTE, NV 89008		
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C 000	INITIAL COMMENTS Surveyor: 13812 This Statement of Deficiencies was generated as a result of an Initial Medicare Survey conducted at your facility on November 16-19, 2009. The facility was found to be in compliance with all Conditions of Participation. Standard level deficiencies were identified as follows: The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	C 000			
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following:] (iv) rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. This STANDARD is not met as evidenced by: Surveyor: 22046 Based on observation and interview, the facility failed to ensure that expired medications and intravenous fluids were removed from the medication storage system and intravenous fluid	C 276			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 276	<p>Continued From page 1 supply areas.</p> <p>Findings include:</p> <p>On 11/17/09, the following expired drugs were identified:</p> <p>Vancomycin Injectable, two vials, expiration date 1/09 Vancomycin Injectable, ten vials, expiration date 3/09 Gabapentin, 85 capsules, expiration date 7/09 5% Dextrose, 250 milliliter IV bag, expiration date 8/09 5% Dextrose, 250 milliliter IV bag, expiration date 10/09 5% Dextrose, 1000 milliliter IV bag containing expiration date 8/09</p> <p>Surveyor: 23119 On 11/17/09, the facility medication storage system was inspected for outdated medications. The following outdated medications were identified:</p> <p>Normal Saline 9% intravenous solution, one liter bag, expiration date 8/1/09 D5 1/2 Normal Saline intravenous solution, one liter bag, expiration date 5/09 Bacteriostatic normal saline for injection, 10 milliliter bottle, expiration 10/09 L.E.T. (Lidocaine 4%, Epinephrine 0.5%, Tetracaine 0.5%) gel, 10 tubes, expiration date 9/23/09 Terbutaline 5 milligram (mg) tablets, eight and one half tablets, expiration date 9/09 Bumex 2 mg tablets, ten tablets, expiration date 10/08</p>	C 276			

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C 278	<p>485.635(a)(3)(vi) PATIENT CARE POLICIES</p> <p>[The policies include the following:]</p> <p>(vi) a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 23119 Based on interview and review of biological testing records the facility failed to ensure a biological test was conducted within the Association of Operating Room Nurses (AORN) recommended guidelines.</p> <p>On 11/16/09, the registered nurse performing the sterilization was interviewed. She reported she ran a biological indicator once a month. She reported she usually sterilized one load of instruments a month, but that some months she might run two or three loads depending on the use and need for instruments.</p> <p>On 11/18/09, the Director of Nurses was interviewed. She reported the facility followed AORN guidelines for their sterile processing.</p> <p>The AORN guidelines for sterilization process monitoring recommendations were reviewed and revealed "Weekly, preferably daily (or each day the sterilizer is used) monitoring of a full load with a process challenge device containing a biological indicator" was the recommendation for routine sterilizer efficacy monitoring. Surveyor: 13812 An inspection of the sterile processing area on 8/16/09 with the nurse in charge of sterilization revealed a pair of visibly bloody surgical scissors</p>	C 278			

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C 278	Continued From page 3 in an open basin in the clean processing room. The nurse observed the scissors and removed them from the room. The nurse indicated she was going to find out how the scissors got into the clean room. A review of the facility policy on contaminated instruments stated, "All instruments that have been exposed to blood or other potentially infectious materials are to be handled with precautions as stated in the Blood Borne Pathogen Hospital Exposure Control Plan." The policy further required that all contaminated instruments be immediately contained in a plastic covered container located in the dirty utility near the old OR, and that dirty instrument containers were transported to the dirty instrument processing room by CS personnel.	C 278			
C 279	485.635(a)(3)(vii) PATIENT CARE POLICIES [The policies include the following:] (vii) If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §485.25(i) is met with respect to inpatients receiving posthospital SNF care. This STANDARD is not met as evidenced by: Surveyor: 13812 Based on record review and interview, it was determined the facility failed to ensure that nutritional screens were done for 21 of 21 patients and that nutritional needs were met for 5	C 279			

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C 279	<p>Continued From page 4 of 21 patients.</p> <p>Findings include:</p> <p>A review of facility policy revealed that the admitting nurse was to complete a nutrition screen on each patient on admission and certain nutritional problems identified would be provided to the dietician consultant for followup evaluation.</p> <p>There was no evidence of a nutrition screen form being completed on 21 of 21 records reviewed. An interview with the director of nursing on 11/18/09 at 8:05 AM revealed the dietician had relocated out of town about four months ago, and that she did not think that nursing personnel were completing the nutrition screens on new admissions.</p> <p>A phone interview with the consulting dietician on 11/18/09 revealed that the screening forms were designed to be completed by nursing and any identified nutrition problems would be faxed to the dietician for evaluation. The list of nutrition problems on the screening form should have included acute pancreatitis according to the dietician. The dietician advised that she had not received any screening forms since she had relocated, and had not received any requests for consultation from physicians or the nursing department.</p> <p>Patient # 5: The patient was admitted from the emergency room on 5/21/09 with a diagnosis of acute pancreatitis. There was no evidence of a nutrition screening form or evidence of a dietary consult.</p> <p>Patient # 10: The patient was admitted on 8/27/09</p>	C 279			

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C 279	Continued From page 5 with diagnoses including renal failure and hyperkalemia. There was no evidence of a nutrition screening form or a dietary consult. Patient # 12: The patient was admitted to the facility with diagnoses including uncontrolled diabetes, gastroenteritis, and cirrhosis. There was no evidence of a nutrition screen or a dietary consultation. Surveyor: 23119 Patient # 2: The patient was admitted from the emergency room on 9/27/09 with diagnoses of gastroenteritis, diabetes mellitus, and volume depletion. There was no evidence of a nutrition screening form or evidence of a dietary consult. Patient # 6: The patient was admitted from the emergency room on 4/29/09 with a diagnosis of diabetes mellitus with infected stasis ulcers of his lower extremities. He had a history of non-compliance with his diabetes. There was no evidence of a nutrition screening form or evidence of a dietary consult.	C 279			
C 282	485.635(b)(2) DIRECT SERVICES Laboratory services. The CAH provides, as direct services, basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include: (i) Chemical examination of urine by stick or tablet method or both (including urine ketones); (ii) Hemoglobin or hematocrit;	C 282			

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C 282	<p>Continued From page 6</p> <p>(iii) Blood glucose; (iv) Examination of stool specimens for occult blood; (v) Pregnancy tests; and (vi) Primary culturing for transmittal to a certified laboratory.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 26896 Based on a review of the hospital and laboratory records, policies and procedures, the hospital policies do not ensure that the laboratory services are being provided in a manner that assures the immediate diagnosis and treatment of the patients.</p> <p>The findings include:</p> <p>1. The physicians are unable to determine the direct laboratory services available based on the 11/23/03 hospital policy "Grover C. Dils Medical Center Policy: Specimen Collections: In-House: Ranges and Specimen Requirements". The hospital laboratory test menu has not been updated to reflect the current laboratory policy "Laboratory Policy and Procedure: In-House Laboratory Test and Procedure" revised on 10/01/08.</p> <p>2. The current hospital policy "Grover C. Dils Medical Center Policy: Specimen Collections: In-House: Ranges and Specimen Requirements" reviewed on 1/11/05 does not reflect the current primary culturing requirements of Quest Diagnostics, the authorized reference laboratory.</p>	C 282			

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C 282	Continued From page 7 3. There was no evidence a written policy and procedure had been developed to ensure that the laboratory tests performed by the in-house or reference laboratory are completed and placed on the patients charts for diagnosis and treatment. This was confirmed during an interview with the laboratory personnel on November 17, 2009 at 1:30 P.M.	C 282			
C 283	485.635(b)(3) DIRECT SERVICES Radiology services. Radiology services furnished at the CAH are provided as direct services by staff qualified under State law, and do not expose CAH patients or staff to radiation hazards. This STANDARD is not met as evidenced by: Surveyor: 26896 Based on a review of the radiology records, policies and procedures, the radiology services are not being furnished in compliance with Federal and State regulations and guidelines governing radiological services and radiation safety. The findings include: 1. The personnel radiation monitoring devices were not being performed and maintained. The film badges used to detect the exposure of personnel to radiation were discontinued after an annual review written by Robert Lackie, M.D. performed on April 10, 2002. The use of film badges was reinstated in October 2009. 2. There was no documentation that the radiology personnel were trained and tested about the hazards of radiation exposure and the management of emergency radiation hazards and accidents.	C 283			

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C 283	Continued From page 8 3. There was no written training procedure available to verify the radiology personnel were trained commensurate with the Federal and State guidelines and the procedures the radiology personnel were allowed to perform. 4. There was no written policy which specified the duties that the radiology personnel is authorized to perform and the level of supervision required for each procedure, which was appropriate to their level of training, experience, and licensure. 5. There were no written policies, developed and approved by the medical staff, that designated which personnel are qualified to use the radiological equipment and administer procedures. 6. There were no written policies and procedures in place to ensure the radiologic equipment had periodic inspections and manufacturers's preventive maintenance performed. 7. There was no evidence that the manufacturers's preventive maintenance and inspections had been performed on the Magnetic Resonance Imaging equipment.	C 283			
C 298	485.635(d)(4) NURSING SERVICES A nursing care plan must be developed and kept current for each inpatient. This STANDARD is not met as evidenced by: Surveyor: 22046 Record review revealed that Patients #3, #7, #15 and #18 did not have a nursing care plan developed during their stay at the facility. An interview was conducted with the Director of	C 298			

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C 298	Continued From page 9 Nurses on 11/18/09. She acknowledged that the nursing staff are required to write a nursing care plan for every patient. She reported that nursing staff do not always write nursing care plans for patients who are frequently admitted to the hospital. Surveyor: 23119 Based on record review and interview the facility failed to ensure a nursing care plan was developed for 11 of 21 patients. Findings include: Review of Patients #6, 9, 11, 13, and 17 failed to reveal a nursing care plan had been initiated. On 10/18/09, the Director of Nurses was interviewed. She reported the policy was for a care plan to be developed for each patient admission.	C 298			
C 305	485.638(a)(4)(ii) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-] (ii) reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings; This STANDARD is not met as evidenced by: Surveyor: 23119 Based on record review and interview the facility failed to ensure that laboratory test results were maintained in the patient record for 1 of 21 patients (#17).	C 305			

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C 305	<p>Continued From page 10</p> <p>Findings include:</p> <p>Review of Patient #17 's record failed to reveal the results of a type and cross match ordered for an ordered blood transfusion.</p> <p>On 11/18/09, the laboratory supervisor was interviewed. She confirmed the laboratory results should be on the medical record and provided a copy of the patient's type and cross match.</p>	C 305			